


ERN

JANUARY 1959



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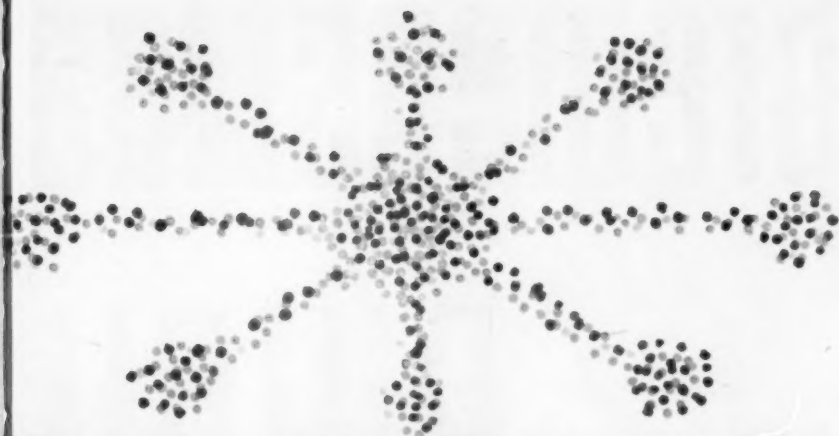
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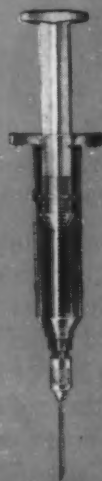


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1. W. Paul Heyond, Jr., M.D.: Etiology and Epidemiology of Viral Hepatitis, The Journal of the American Medical Association, November 2, 1957, page 1091.

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FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. 166:129, Jan. 11, 1958.

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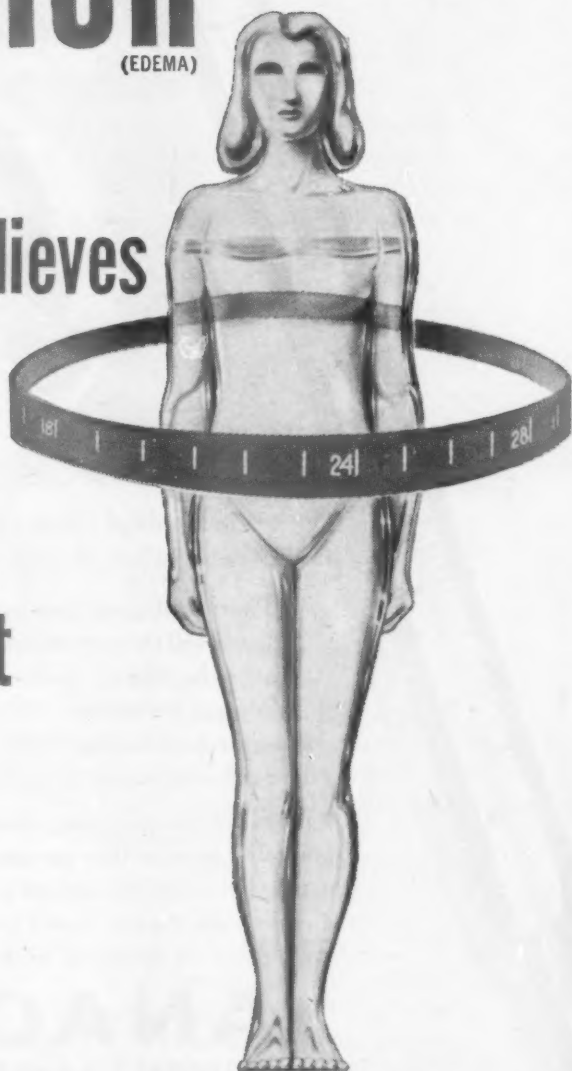
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Reference: 1. Brownlee, George D.: *A Comparison of the Antipyretic Activity and Toxicity of Phenacetin and Aspirin*, Quar. J. of Pharmacy and Pharmacology, 10:609-620.

RN letters

MERGE WITH A.M.A.?

DEAR EDITOR: The Missouri R.N. who suggests that the nursing profession be taken under the wing of the A.M.A. is just plain impractical. I shudder to think of the consequences.

We need our own organization. What's more, we need union within its ranks.

So how about strengthening the A.N.A.? It will do what we want it to do if we'll only support it.

M. Richardson, R.N.
Glendora, Calif.

QUESTIONS?

DEAR EDITOR: May I suggest you publish a monthly feature devoted to answering nurses' questions? It might be called "Ask RN."

Questions accepted for answering would naturally have to be of interest to nurses the country over. Example: I am a registered, professional nurse, the product of a three-year, accredited school of nursing. Now I wish to "go for a degree." Which colleges offer the most credit for three-year training?

I believe such a feature would be heartily appreciated by your readers and would give the editors still

more ideas about what is acutely interesting to nurses.

You do such a magnificent job! I always call the magazine *RN Preferred* because it's the one we nurses read most eagerly and enjoy most thoroughly.

Margaret Gerard, R.N.
Detroit, Mich.

RN thanks Miss Gerard for her fine suggestion and invites you herewith to "Ask RN." If your questions are numerous enough—and of broad enough interest to nurses generally—we'll be happy to publish this proposed feature regularly.—Ed.

RX FOR UNIFORMS

DEAR EDITOR: Here's a novel idea that might be useful to some nurses: I dip my discarded uniforms in a solution of Rit or Tintex—and find they make very good knock-about dresses.

Caroline Duffy, R.N.
Paterson, N. J.

MUM'S THE WORD

DEAR EDITOR: It's only natural for a seriously ill patient to confide in a "special" and to reveal innermost



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letters

secrets to her. Such patients turn us not only for physical comfort but also for spiritual comfort and a psychological "lift."

While we assure them and try help them achieve peace of mind let us resolve to keep their revelations private and confidential. Let us glory in the trust each patient places in us.

Sophia G. McGrath, R.N.
Concord, N. H.

SMOKING ON DUTY

DEAR EDITOR: I appreciate the stand taken by Eimada Knophlock. Those few of us who don't have the filthy habit of smoking are constantly forced to work with smoking nurses.

If I'm ever a patient and a nurse comes in smoking (or smelling of smoke), she'll go out faster than she came in.

Recently I was interviewed by an assistant director of nurses—only to have smoke blown in my face.

Clara Roder, R.N.
Hot Springs, Ark.

PREGNANT COMMENT

DEAR EDITOR: A recent RN article asks: "Should the Pregnant Nurse Work?"

You betcha!

I worked until three weeks before my first child was born and would have been most unhappy had I been denied the privilege.

Where did I work? In a psychi-



for routine office instrumentation, to ease the pain of minor surgical procedures, removal of sutures, proctological examination.

for sunburn, cuts, minor burns, to stop the sting and make the patient more comfortable (especially the little ones)

for a variety of skin irritations (such as insect bites), to stop the itching and soothe inflamed and swollen surfaces.

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letters

atric unit—and on a rotating shift.

I'm sure the happiness within me radiated to my patients. For I established rapport with some who had nothing but sharp words for my fellow workers.

As one male patient put it, "You're so darn happy from the inside out, you make me forget my troubles."

Patricia Griffin, R.N.
Playa del Rey, Calif.

Mrs. Griffin was named "Mrs. California" in her state's 1958 homemaker contest.—ED.

NURSELESS POLICY-MAKING

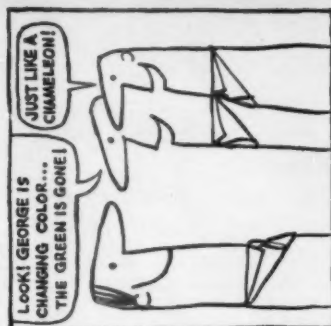
DEAR EDITOR: Why are nurses so rarely represented on the policy-making boards of community health and welfare organizations?

Consider, for example, your local board of health, the board of trustees of your community hospital, and the board of directors of your local children's home: Is there a nurse on any of these boards? I'll wager there isn't.

In public health departments and hospitals especially, nurses should have board representation. They should have it if only because they comprise the largest group of employees in both instances.

And surely nurses have specialized knowledge of child growth and development—knowledge that would be helpful to the directors of any children's home.

What can we do to promote the



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letters

presence of nurses on such policy-making boards?

I would like to know how other RN readers feel about this.

Elizabeth Reed, R.N.
Jacksonville, Fla.

The sooner we join a union and let someone fight for us, the better off we'll be. I'm all for it—but I can't swing it alone.

R.N., California

WHAT IT TAKES

DEAR EDITOR: No wonder 3,000 nurses in Minneapolis and St. Paul won higher pay and better working conditions. They had the nerve and backbone to stand up for their own best interests. And that's what it takes.

Too many of us sit by like a lot of dummies and let everyone (including the doctors) walk over us.

LEGAL RISKS

DEAR EDITOR: I suggest you reprint—at least once a year—your article, "Are You Risking a Malpractice Suit?"

M.D.s as well as R.N.s should read it. Some doctors I've worked with have had absolutely no regard for our professional ethics and legal responsibilities.

R.N., North Carolina

END



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1. Bruschi, C.A., et al.: Md. State Med. J. 5:36, 1956



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You will be especially pleased with its smooth consistency, appealing mild fragrance, and its non-greasy, non-sticking properties. Silicare leaves no visible film or coating to impair your manual dexterity.

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ment being observed in 95.6% of cases by regular use of Silicare.

—Le Van, P., Sternberg, T. H. & Newcomer, V. D.: Cal. Med. 81:210, 1954.

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RN news

Living Costs Soar—But Hospital Costs Rocket

Consumer prices have just about doubled in the last twenty years. But note this: Hospital costs have tripled in that time.

These facts emerge from a study of the Government's Consumer Price Index for 1938 and 1958. In the twenty-year period, the study shows, rents went up 60 per cent, food 151 per cent, cars 125 per cent, babies' shoes 171 per cent—and hospital costs a whopping 300 per cent.

The reason for hospital costs having tripled? Wage boosts, chiefly, says Ray M. Amberg, president of the American Hospital Association. Mr. Amberg points out that it now costs an average of \$28.81 per patient-day to operate a general hospital. In some instances, he adds, personnel costs alone may exceed \$22 per patient-day.

Device Helps O.R. Staff 'Hear' Cardiac Arrest

A warning that the surgical patient's heart has ceased to function properly can be heard by every member of the O.R. team when the patient has a newly devised "mini-

ature cardiac monitor" strapped to his wrist.

The instrument produces a constant loud "beep" that stops when cardiac arrest or ventricular fibril-



lation occurs. Battery-operated and weighing less than six ounces, it can be worn by the patient from the time he leaves the preoperative unit till he's out of danger in the recovery room.

Dr. William F. Veling of Grace Hospital, Detroit, describing the electronic monitor in a recent issue of the *Journal A.M.A.*, says it "enlists the attention of the entire op-

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By Solomon Garb, M.D., Cornell University The purpose of 120 tests explained. Obtaining specimens, precautions. Laboratory procedures (summarized). Normal ranges. Plus quick reference tables. 160 pages, **\$2.00.**

ESSENTIALS OF THERAPEUTIC Nutrition Solomon Garb, M.D.

The emphasis of this brand new book is on the patient, on correlation with disease; helps the nurse take on responsibilities that are rightly hers. Includes principles of nutrition, common therapeutic diets, reference tables. 160 pages, **\$2.00.**

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SPRINGER PUBLISHING CO., Inc., Dept. 9R1
44 East 23rd Street, New York 10, N.Y.

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news

erating room team, but frees their eyes and hands for other duties."

The monitor turns itself on when it's taped to the patient's wrist, goes off automatically when the pressure is released. It can be used for infants by attaching another lead wire and strapping that to the baby's wrist. It can also be made to activate a light or meter in the nursing station.

Since the monitoring device is small, reliable, and relatively inexpensive, Dr. Veling suggests that it be used on all critically ill patients, especially those with coronary disease. He predicts that, at least in the O.R., the portable cardiac monitor will soon become "as commonplace as the stethoscope."

Private Duty Pay in Massachusetts has been raised to \$17 for day-shift care, \$19 for evening-shift care, and \$18 for night-shift care. The new rates, approved by the M.S.N.A. on a trial basis, increase the patient's cost for round-the-clock private duty nursing from \$45 to \$54 a day.

New Scholarship Fund To Aid Recruitment

More high-school graduates may choose nursing as a career if the National Foundation's new scholarship program works out as expected.

The Foundation, supported by The March of Dimes, plans to spend \$12,000,000 over the next

ten years to fund a program in nursing health and medicine.

Planned for some scholarship studies, the Foundation's basis and mission. The with

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ten years on the nation-wide pro-gram. Its aim: to ease shortages in nursing and in four other major health fields (medicine, physical and occupational therapy, and medical social work).

Plans call for annually granting some 500 four-year college scholarships, each worth \$500 a year. Students will be selected by the Foundation's local chapters on a basis of scholastic record, aptitude, and motivation.

The program is slated to begin with the 1959-60 academic year.

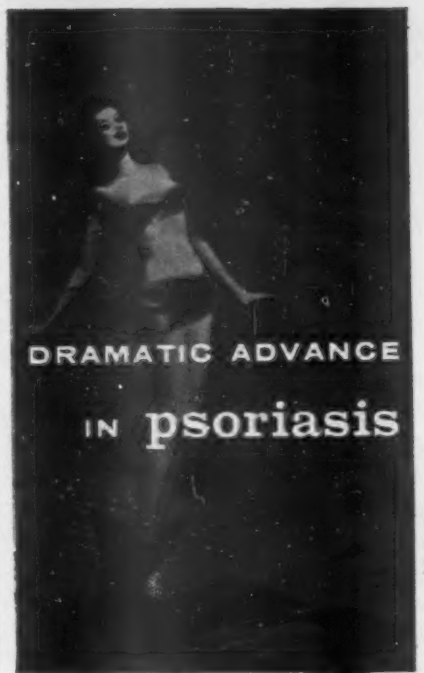
Emergency Oxygen for home use can now be purchased at the corner drugstore. A portable “Oxy-aid” kit contains a twelve-minute supply of U.S.P. oxygen and a plastic face mask. A patented regulator is said to control flow at six liters per minute. In addition to standard emergency uses, the manufacturer recommends the device for “fatigue, driving exhaustion, and migraine headaches.”

Biologist Warns Against D-less Store Milk

There's a tendency among dairies to save the cost of adding vitamin D to the homogenized milk they sell in stores. And D-less milk could lead to a widespread recurrence of rickets among children.

That's the gist of a warning issued by Biologist H. T. Scott of the Wisconsin Alumni Research Foundation.

More▶



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(1) Flesch, P.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). (2) Bleiberg, J., and Saltzman, J. A.: Clin. Med. 5:485 (Apr) 1958. (3) Bleiberg, J.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). (4) Clyman, S. G.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). *Trademark

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news

Consumers, says Dr. Scott, need to be reminded that homogenization and vitamin D are not synonymous—as many think. He urges that milk-carton labels be read carefully to make sure that the milk actually is fortified with vitamin D.

New Barbiturate Antidote Made Available

Medical men hope that the recent introduction of a new drug, bemegride (marketed as Megimide), will help cut the death toll from barbiturate poisoning—which ranks as the leading cause of death by drugs. When injected by vein,

the new antidote is said to bring back quickly the vital reflexes that maintain respiration and blood pressure.

Previous efforts to find an agent that really combats the barbiturate molecule have not been successful. Analeptics, such as pentamethylentetrazol (Metrazol) sometimes help in the treatment of barbiturate overdosage; but because they are central stimulants, clinicians say they're apt to cause convulsions and other ill effects.

Just how bemegride works is still debatable. At first, it was thought to act by "competitive inhibition"—a process by which a

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news

chemical's molecules keep others of similar structure from attaching themselves to body tissue and producing drug effects.

But recent research has cast doubt on this theory. It now seems more likely that bemegride stimulates depressed brain cells in the same way older drugs do—and therefore may prove to have some of the same drawbacks.

Meanwhile, bemegride therapy—combined with oxygen inhalation, artificial respiration, and other procedures—is expected to be at least a useful adjunct in treating victims of barbiturate poisoning.

M.I.T. to All R.N.s:

Do you know anyone who has survived radium poisoning for twenty years or more? Many such persons are still alive, says the Massachusetts Institute of Technology, which is seeking your help in locating them for study purposes.

Survivors include some 2,000 who swallowed radium paint while working on luminous watch dials in the Nineteen Twenties the Cambridge institution adds.

Formula Thermometer Can Be Sterilized

The "Formometer," a new thermometer for testing the temperature of baby formulas, can be placed in the top of a nursing bottle and sterilized along with the rest of the formula. A special nipple

holds the thermometer suspended in the bottle.

When a day's supply of formula is made at one time, "Formonipples" are placed on all the bottles and the thermometer is suspended in one of them. Then the whole supply is sterilized by the terminal method.

At feeding time, the bottle with the thermometer is removed from the refrigerator and heated to the correct temperature. Then the thermometer is removed and placed in the next bottle, ready for use. At the same time, the Formonipple is removed from the heated bottle and replaced with a standard nursing nipple.

Formometers can be used for testing the temperature of food and bath water, as well as formulas. They come in large and small sizes to fit standard nursing bottles.

New Design Improves Bandage Scissors

A new bandage scissors is reported to be safer and more efficient than the regulation kind. Instead of having the familiar acorn-shaped protective tip, the lower blade of the new scissors has a smooth, rounded point. This blade, it's said, can be slipped underneath the tightest bandage without inflicting pain and the full length of both blades can be used for cutting.

The new model also has a notch on the inner surface of each handle, designed to fit the hub of a hy-



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news

podermic needle. This makes it possible to use the scissors for removing a needle from a syringe.

Dr. Preston Burnham of Salt Lake City, who described the improved bandage scissors in a recent issue of the *Journal A.M.A.*, says he has used it on all kinds of bandages and dressings and finds it superior to the standard model.

Doctors Find New Way To Cement Fractures

Diseased or fractured bone ends can be bonded by pouring a substance called polyurethane (Ostamer) into the involved site. So say Drs. Michael Mandarino and Joseph Salvatore of Hahnemann Hospital, Philadelphia, in a report to the American Association for the Surgery of Trauma.

The substance swells, hardens into a rigid foam, and becomes an integral part of the bone, the M.D.s explain. It "sets" in twenty to thirty minutes, they add, but requires eighteen to twenty-four hours to harden completely, during which time a splint is used.

Nursing-Home Records Checked for Fraud

Bribery and bill-padding accusations against operators of private nursing homes in New York City has led to a sweeping investigation. At last report, the records of some 127 nursing homes were being

scrutinized by city officials in a search for evidence. Several thousand welfare patients, whose care reportedly costs the city millions of dollars annually, are cared for in about ninety of the homes.

More Traineeships Coming Up?

The new Congress, convening this month, will be asked to extend the Government's nurse-traineeship program for at least five more years, Washington sources predict.

The three-year program, set up in 1956, provides grants to R.N.s for advanced study in administrative, supervisory, and teaching methods. Some 1,500 such grants totaling \$6,000,000 have been provided for the current fiscal year, which ends next June 30. The awards are made by the Public Health Service through 99 participating college-level nursing schools.

M.D. Says Lollipops Are Good for Sick Kiddies

"Lollipops help protect the sick child's liver," says Dr. Charles A. Tompkins in the December Parents' Magazine. "Since the supply of sugar in his liver is small compared to yours," he says, "it is more quickly exhausted"; so giving the child lollipops or some other form of concentrated carbohydrate helps avoid depleting the liver of its glycogen supply. [More on 84]

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RN *literature and samples*

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UNIFORM FASHIONS: A new 1959 catalog shows professional styles with dirndl skirts, permanently pleated skirts, embroidery trim, in complete size ranges. Accessories and men's professional wear are also included in this thirty-two-page book. BUDGET UNIFORM CENTER. **A-3**

PLASTER OF PARIS BANDAGES: A folder describes Stucca hard-coated

plaster of paris bandage, in which the plaster is held securely to the gauze for neat and efficient application. ACME COTTON PRODUCTS CO., INC. **A-4**

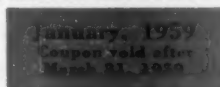
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Skin Grafting for Burns

An up-to-the-minute report
on current methods of
treating third-degree burns

By Curtis P. Artz, M.D.

Every third-degree burn should be covered with skin grafts. Such grafts minimize disfigurement. They also prevent septicemia.

All too often, a patient with extensive third-degree or full-thickness burns will survive the initial shock and fluid loss only to succumb a few days later to overwhelming infection.

Even with antibiotic therapy and meticulous aseptic technique, septicemia is the greatest single threat to the lives of patients with third-degree burns of 45 per cent or more of the body surface.

Septicemia occurs when bacteria proliferate in the dead tissue of the burn wound, attack healthy surrounding tissue, and

DR. ARTZ, Associate Professor of Surgery, University of Mississippi, Jackson, Miss., is a former director of the Brooke Army Hospital's burn center at Fort Sam Houston, Tex. He is also co-author, with Dr. Eric Reiss, of "The Treatment of Burns," published in 1957 by the W. B. Saunders Co., Philadelphia.

SKIN GRAFTING FOR BURNS

swarm into the blood stream. Bacteria can come from outside the wound or from the crypts of the patient's sweat glands and hair follicles. We've learned that the best way to prevent this invasion is to remove the dead tissue quickly and replace it with healthy skin grafts.

The dead tissue of a third-degree burn is called eschar. Ideally, the outer surface of the eschar acts as a protective cover until the viable tissue under it begins to granulate and heal. Then the eschar sloughs away.

Nature Needs Help

But since the eschar also acts as a host to bacteria, the process by which nature removes it has to be speeded up or even bypassed.

It can be speeded by frequent changes of dry, sterile dressings or by continuous warm saline soaks. It can be bypassed by surgical excision.

In exposed burns, dry dressings are begun about the fourteenth day and changed thereafter every four or five days. They drain purulent matter from the wound and help loosen the eschar.

When the old dressing is re-

moved, part of the loosened eschar comes away with it. The new dressing protects the now partially exposed wound from outside contamination and continues to soften the eschar.

What Kind of Dressing?

Dry-dressing changes may number as many as twenty before the patient is discharged. The Brooke Burn Dressing, developed at the burn center at Brooke Army Hospital, is easy to make and satisfies these four basic requirements:

(1) It's occlusive, so it protects the wound from outside contamination. (2) It's bulky, so it acts as a splint to immobilize the burned part. (3) It's absorptive, so it hinders the growth of bacteria by draining off purulent exudate. (4) It's resilient, so the danger of pressure injuring delicate tissue and blood vessels is minimized.

Another, and safer, way to remove the eschar is by applying warm saline soaks to the wound every four hours. But since this procedure is so time-consuming that it requires a special duty nurse, doctors usually order it only if infection cannot be controlled without it.

When applying saline soaks, the nurse wears sterile gloves and mask. First, using an irrigating syringe, she soaks the old dressing with saline solution.

Then, using a forceps, she removes the entire dressing and any bits of loose dead tissue. (Disturbing firmly attached eschar would cause [More on 66])

Why Not Mark O.R. Instruments by Name?

By Sister M. Annette, O.S.F., R.N.

The operation—an orthopedic case—is going none too well.

"Chisel!" barks the worried surgeon.

The sharpness in his voice so jolts the scrub nurse that her mind goes blank. Which is the chisel? Which is the osteotome? Precious seconds tick by. The impatient surgeon grabs the chisel himself.

A situation of this sort could be serious. Yet it can be avoided in the first place—simply by stamping each instrument with its name.

Besides lessening the danger of a mental block, marked instruments would yield other advantages:

¶ Students would be able to study instrument names in between operations.

¶ The O.R. instructor's job would be simplified. (In fact, the identification of instruments could be taught by almost any O.R. nurse.)

¶ On-the-job instruction of auxiliaries employed in the instrument room would be expedited.

¶ And the names of instruments would be uniform. (A nurse educated in the East, for example, wouldn't have to relearn instrument names when she moved to another part of the country.)

END

If you're barred from nursing when you move to another state, you may well ask:

WHY NOT NATIONAL

Here you'll find out why it's impossible, what can be done



THIS ARTICLE was written in consultation with **Bernice E. Anderson, R.N., ED.D.,** Professor of Nursing Education at Teachers College, Columbia University. Miss Anderson was long-time chairman of the A.N.A. Committee on Legislation and a member of the A.N.A. Special Committee on State Boards of Nursing.

BY PATRICIA D. HORGAN, R.N.

LICENSURE?

Have you a yen to move down South or out West? Do you want to go back to your home town? Or is your husband being transferred?

If so, and if you still plan to nurse, you must of course be licensed by the state you go to.

But you may discover that getting a license isn't so simple. You fill out forms, pay fees, write for transcripts and collect signatures—and wait. While you wait, you begin to think:

Why can't an R.N. have one license, good in every state and territory of the United States?

Supporters of national licensure say it would:

¶ Allow nurses to move freely among the states and territories, thus easing the nurse shortage.

¶ Save valuable time, what

with no waiting for approval, no delay while credentials were being checked, and no writing to schools for records.

¶ Save nurses money on license fees, which now range from \$10 to \$30* for each additional state registration sought.

¶ Set uniform standards for R.N.s and do away with the variations from state to state.

But all this is nothing more or less than wishful thinking. For the cold, hard truth is that national licensure is legally impossible. Here's why:

Article X of the Bill of Rights says: "The Powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

One of these states' rights is police power. It allows each state to look after the general welfare of its citizens, which includes the regulation of professional practice—as in medicine, law, dentistry, and nursing.

The earliest statutes control-

*The source of this and other asterisked material in this article is the American Nurses Association.

WHY NOT NATIONAL LICENSURE?

ling the practice of nursing within state borders were passed in 1903 by North Carolina, New Jersey, and New York. By 1952, every jurisdiction (the forty-eight states, the District of Columbia, Alaska, Guam, Hawaii, Puerto Rico, and the Virgin Islands) had similar laws.

Reciprocity Is Out

Short of national licensure, then, what can we hope to get? Reciprocity of licensure among all the states? No.

True reciprocity would require the states to enter into agreements among themselves to license the nurse-candidates of one another. But such interstate agreements (or treaties) are not permitted under our form of government. For this reason, there can be no such thing as true reciprocity.

For years you may have been content in the belief that your original license gives you "reciprocity with every state except . . ." But this so-called reciprocity is really a misnomer. It's a misnomer for a process better described as "endorsement."

More often than not, a state will endorse an R.N.'s original license if it's in good order and

if she meets the standards set for nurses by that state. But if she doesn't meet these standards, the state reserves the right to refuse licensure, to re-examine the nurse, or to stipulate that deficiencies be removed before a license is granted.

Take the case of Miss A. She's licensed to practice nursing in State X. She received her State X license by examination. Her total score was high enough to give her a passing average for each section.

She applies to State Y for licensure. But State Y requires that *each area* of nursing tested in the examination be passed with a minimum score. So Miss A, who scored poorly in the area of psychiatric nursing, may have to be re-examined in that subject. She may even be obliged to complete a period of make-up study in psychiatric nursing before sitting for the exam.

It's true that we now have an official, nationally accepted test of nursing knowledge and skill, known as the State Board Test Pool Examination. *But each jurisdiction still decides what passing score it will recognize.*

This is necessarily so because every examining board must take

into account the quality of nursing education available in its state. It must also consider the performance that can be expected of graduates there.

The variation we find from coast to coast in nursing-education standards is one reason why even a national nurse examining board is impractical now. There are other reasons, too:

¶ Before a national examining board could be seriously considered, at least a reasonable number of the states would have to

agree to accept not only its questions but also its scoring standards. Getting them to do this would be a monumental job.

¶ A national examining board would depend for its existence on fees paid by those it examined. The usual fee might well have to be \$100 or so, which many nurses would regard as prohibitive.

Despite all this, interstate licensure *can* be simplified. How? By voluntary agreement that doesn't violate the interstate treaty ban. [More on 72]



"You have a choice for the main dish: asparagus, spinach, or lentils."

How to Help Teen-Agers With Acne



By Eileen McGloin, R.N.

You can do much to minimize the physical and emotional scars of this 'major disease of adolescence'

"To cope successfully with acne, you've got to know something about the teen-ager's personality as well as about the disease itself." So say the R.N.s who work in the Adolescent Unit of The Children's Hospital in Boston.

Some teen-agers who go to the Unit don't admit at first that they want help with their acne. They say they've come for a check-up, or because they haven't been feeling well lately, or for some other vague reason. So it's up to the doctor or nurse, at some point in the physical exam, to bring up the subject of acne.

Teen-agers are intensely concerned with everything about themselves, including their bodies. But they resist the idea that there's anything wrong with them. The nurse or doctor must thus use a roundabout approach.

THIS ARTICLE was prepared with the cooperation of J. Roswell Gallagher, M.D., and Alice Leddy, R.N. Dr. Gallagher is chief and Mrs. Leddy is head nurse of the Adolescent Unit, Children's Hospital, Boston.



Teaching the teen-ager the principles of good skin care helps her escape the physical scars of acne. This clinic nurse is showing a patient how to apply sulfur lotion.



Listening to the teen-ager talk about her acne helps prevent serious emotional scars. Here the nurse encourages a teen-ager to verbalize her fears about "not being liked."

It might go something like this:

Nurse: "Do you ever have any trouble with your skin?"

Teen-ager: "Oh, now and then. Sometimes it breaks out."

Nurse: "Do you do anything for it?"

Teen-ager: "Nothing much."

Nurse: "Would you like some help for it? We can clear it up pretty fast."

Teen-ager: "Well . . . O.K. . . . I guess it wouldn't do any harm."

Despite the seeming lack of

enthusiasm, this teen-ager needs and wants treatment. Society puts a high value on smooth, clear skin; and when the adolescent doesn't have such skin, he or she feels ashamed. Some teen-agers with severe acne have been so depressed as to think occasionally of suicide.

Acne can delay a child's emotional and social development. So it should be taken care of, not pushed aside by simply telling the boys and girls who have it

HOW TO HELP TEEN-AGERS WITH ACNE

that they'll outgrow it. They may be a long time outgrowing the physical and emotional scars it can leave!

Acne is related to maturation. It strikes most often around age 16. But younger adolescents who mature early appear to have the same rate of incidence as do 16-year-olds.

The relationship between acne and maturation apparently results from the stepped-up rate of androgen production during puberty. A high testosterone level in boys and a high progesterone level in girls produces an increase in the number, size, and activity of the sebaceous glands. These glands secrete sebum, a greasy lubricating substance, in the pores of the skin.

What Causes the Lesions

The trouble starts when keratin, the insoluble protein that makes up the greater portion of skin, hair, and nails, gathers at the mouths of the sebaceous glands. This produces inflammatory changes in the pores and blocks the escape of the sebum. When this process causes the pores to atrophy and dilate, the sebaceous glands and their ducts then become susceptible to

infection. Clinically, this sequence appears as comedo, papule, pustule, and cyst—acne's all too familiar lesions.

Infection occurs most often in adolescents who are sensitive to staphylococci. *Staphylococcus albus*, commonly found as part of the normal flora of the skin, becomes pathogenic in the plugged pores, and pyoderma can result. Acne that progresses to infected pustules and cysts often results in the deep scars or pits that are one of the worst features of the disease.

Only about 15 per cent of patients seen at the Adolescent Unit are serious acne cases. For the other 85 per cent, a simple program is advised. This includes thorough but gentle face washing; a sulfur lotion applied at night; and advice about the value of good hygiene.

It's usually up to the nurse from there on. She teaches the teen-agers how to wash their faces without rough scrubbing, complexion brushes, heavy cold creams, or oily soaps. She advises gentle massage with a mild soap and a face cloth three or four times a day, or as often as needed to keep the skin free of oil. And she warns them about

the damage they can do if they pick or squeeze their skin.

One other point is important in this otherwise conservative program. The sulfur lotion, used

to dry the skin and encourage surface peeling, is a chalk-white one. It's applied only at night. During waking hours, the teenagers are supposed to keep their

'Ideal' Anesthetic Being Tested

By Morton J. Rodman, Ph.D

Spurred by hopes that their long search for the "ideal" anesthetic may be paying off, anesthesiologists are putting a new compound, Fluothane, through its clinical paces.

Fluothane vapors don't explode or burst into flame. They're pleasant to inhale and don't irritate delicate respiratory tract membranes. So patients don't fill up with bronchial fluids or choke on excessive salivary secretions.

Deep anesthesia comes on quickly with little struggling or excitement. Recovery is rapid, too.

But Fluothane is about four times as potent as ether. And such power doesn't leave much margin for error. Inhaling too much too quickly can knock out the brain's breathing center and send blood pressure plummeting.

These dangers make it essential that concentrations of the anesthetic be carefully controlled. So far, the best way of doing this is to use a calibrated vaporizer that measures the concentration of vapor reaching the lungs.

Anesthetists are now testing different types of such devices to determine which is most accurate. When they find one that keeps Fluothane concentrations within safe bounds, this anesthetic will probably come into its own.

Until then, Fluothane—for all its advantages—will probably remain too risky for routine use.

END

HOW TO HELP TEEN-AGERS WITH ACNE

faces scrupulously clean and not to use any "cover-up" lotions. This, of course, means no cosmetics for the girls.

One of the nurses tells a story of a group of girls who'd been coming to the clinic and who seemed to be making very poor progress. As far as she knew, they were following the program carefully. But when she questioned them about it, she could tell there was something they were all doing that they were trying to conceal from her. Finally one of the girls broke down.

"We've just got to use make-

up when we go to the Friday night dances," she blurted out. "We simply couldn't go looking like this!"

"After that," says the nurse, "I decided it was better to let the girls use make-up once a week, and show them how to do it properly, than to have them use it secretly and do it all wrong. So lipstick and light face powder are now allowed on Friday nights, with emphasis on the importance of washing every bit of it off the minute they get home."

R.N.s in the [More on 78]

Toss-up

A patient at our psychiatric sanitarium had been given permission to go to the theatre. I went with her as nurse-chaperon, in "civilian" dress.

After a pleasant evening, I hailed a cab to take us back to the sanitarium. Instead of referring to it by name, I gave the driver the street number.

On our arrival, since I was going off duty after returning my charge, I told the cabbie to wait. I then checked my patient in and bade her good night.

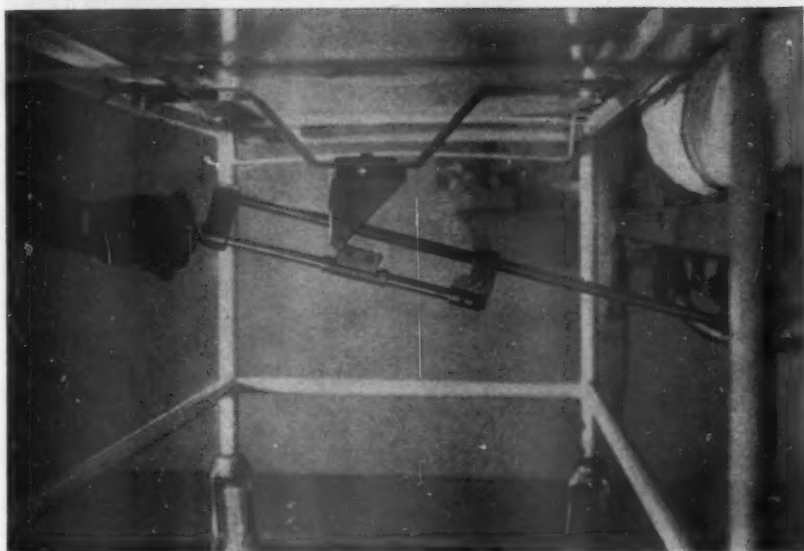
Back in the cab, I gave the driver my home address, lit a cigarette, and relaxed. My serenity was soon shattered when the driver, chuckling, turned to me and said:

"I been layin' bets with myself all the way up town on which one comes out!"

—GRACE BROWN, R.N.

For each previously unpublished anecdote accepted, RN will pay \$15 to \$25. Address: Anecdotes, RN, Oradell, N.J.

Device Safeguards Transfer of Patient



You may have wished for a safety device that would protect your patient from falling between bed and stretcher when you're transferring him from one to the other.

A nurse, Mrs. Esther E. Sullivan of Howell, Mich., saw a way to make the wish come true. So she took the idea to her father, Emil Haugard, an inventor. The result: a patient-transfer safety device, called the Stretch-

er-Grip, that's now being used by a number of Midwest hospitals.

The Stretcher-Grip is permanently mounted on the underside of a wheeled stretcher and has a rubber-tipped hook that grasps the bedrail. The grip works like the emergency brake on your car.

Nurses say that both they and their patients are spared many anxious moments by the knowledge that bed and stretcher are locked securely together. **END**



WHAT HAS HAPPENED TO NURSING

EN believes that nurses want to be informed of major criticism levelled at profession. Hence, this arresting example, excerpted from the Maryland State Medical Journal (Vol. 7, No. 7).

Dr. Kautz's indictment of nurses is no isolated case. It is but one of several that have appeared in the medical press in recent months. It reflects an attitude among physicians that is by no means uncommon.

If neither you agree with the author or not, the editors will welcome your comments.

Even the most casual observer, if he has lived long enough to witness the differences between the attitudes of current today and that of, say, thirty years ago. The attitude of the average nurse has changed not only with regard to her feeling for her patient, but also with regard to the doctor who takes care of the patient.

Happily, this is not universally true. Some nurses today are just as fine as any nurse ever was. To show every doctor takes off his hat and bows, acknowledges his dependence, and is happy to re-

importance, and is happy to create when a pleasure it is to work.

obvious, and are dressed in them. They are, however, particularly directed in their own way, when asked to take an order or help with a dressing, display boredom and annoyance. Their attitude toward their customers is just as improper.

What has brought about this change in attitude and thinking was lately found in each of the number of surveys today. Undoubtedly part of it is that I believe a large part is due to the changing vociferousness pervaded our land since the middle Nineties.

The *Arabian* political phi-

...and our people have been taught that they owe nothing to anyone but themselves. We have been living in an era of "hand-outs" and "give-aways." Theft and corruption have been con-

WHAT HAPP

IN THE BELIEF that nurses want to be kept informed of major criticisms leveled at their profession, RN reprinted in November, 1958, an indictment of nurses by Amos R. Koontz, M.D., from the Maryland State Medical Journal.

While Dr. Koontz took pains to point out that there are many exceptional nurses to whom his complaints were not directed, he charged that in general the modern nurse lacks the devotion to duty that characterized her colleague of thirty years ago. He said that she is a clock-watcher who often displays boredom and annoyance at the doctor's requests, and that she lacks politeness, is undisciplined, and has little sense of responsibility. He also suggested that higher educational standards for nurses may have led to deteriorated patient care.

Response to Dr. Koontz' article came in a record-breaking flood of letters, almost equally balanced between cheers and jeers. Here, greatly condensed, is what the nurses say.

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Say

WHAT HAPPENED TO NURSING

"Hurray for Dr. Koontz," says L. Howe* of Novelty, Ohio. "I'm glad to know that at least one doctor has the courage to state his opinions on the attitudes of nurses today."

A completely opposite viewpoint is expressed by "Anirate R.N." from Plainview, N. Y., who says, "I've never been so infuriated in all my life. I'm one of Dr. Koontz' clock-watchers and I offer no apology for it. I have to be home when my children return from school and I can't afford a sitter. So what's the alternative? I suspect Dr. Koontz fears that too much education (if there is such a thing) will make nurses demand their rightful place in the community and a commensurate income."

Between these extreme atti-

tudes are many suggesting that the answer to present-day nursing problems lies in better communication, more cooperative effort, and fuller understanding by both doctor and nurse of each other's problems. One nurse puts it this way:

"Let's stop looking at each other in such narrow perspective. Now is the time to cement the bond of trust and loyalty between our professions. Dr. Koontz, we nurses are on your team."

Most nurses who concur with Dr. Koontz' indictment do so whole-heartedly. For example:

Lina Arthur of North Haven, Conn.: "I agree with everything Dr. Koontz said."

Gladys Harrison of Rochester, N. Y.: "We nurses have deserved this 'spanking' for a long while."

Marion R. Page, West Palm

*All those quoted are R.N.s, unless otherwise noted. The editors have also respected requests for anonymity from nurses fearing reprisal if identified.

NURSES REPLY TO CRITICISM

Beach, Fla.: "I would like to see this article reprinted in all the nursing publications. Perhaps it would help arouse the profession as a whole to the deplorable results of its overworked efforts to produce 'super beings' instead of real nurses!"

Many of those who agree with Dr. Koontz admit they are older women. But Josephine Hickey of Corning, N. Y., wants to make clear that "some of the younger nurses, too, are con-

cerned with the situation. We hope Dr. Koontz' article will be taken to heart by the many nurses he reached through *RN*."

A practical nurse who is proud of having an R.N.-daughter, joins the pro-Koontz chorus: "It makes my heart ache when I see an R.N. who's not using her knowledge and training to the utmost. I keep wondering how doctors can carry on their work without demanding that nursing conditions be changed."



"Your sister just called. She wants you to baby-sit tonight!"

Most of the nurses who express opposition to Dr. Koontz' views single out specific reasons for their disagreement. And, almost to a nurse, they conjure up in their defense the old proverb: "People who live in glass houses shouldn't throw stones."

Elizabeth Brandimore of Tallahassee, Fla., says, "The general consensus in my vicinity seems to be that the trouble with nurses is *doctors*."

Orpha N. Plyler of Erie, Pa., says, "I'm an old nurse, but I believe the general run of R.N.s can find as much to gripe about in the *doctors'* conduct as Dr. Koontz has found to gripe about in the nurses'."

Says Florence M. Schneider of Jamaica, N. Y., "The breakdown in hospitals didn't begin with the nurses. I could match Dr. Koontz' article word for word with an indictment of the medical profession."

Sylvia Gould of Ithaca, N. Y., wraps up the "glass house" charge by remarking that "Dr. Koontz has a picture window in every wall!"

The doctor also comes in for a tongue lashing on the score of written orders and prescriptions.

Says Virginia G. Rand of

Lesire City, Fla., "Even a neophyte realizes that it's the doctor's function to write out, as well as sign, his own orders."

J. Barnard of San Angelo, Tex., adds, "Whoever heard of a doctor letting a nurse call in a prescription for him?"

The "con" writers reflect a modern distaste for the custom of the nurse always standing in the doctor's presence. For instance:

Rachel Francis of Hill, N. H., points out that "a nurse's feet are an important part of her stock in trade. They're not made of clay, but of flesh and fallen arches, calluses and corns."

Katherine L. Ashlock of Iowa City, Iowa, says, "It's difficult to comprehend what possible bearing a nurse's failure to get to her feet when addressed by a physician could have on a patient's welfare."

An unusual point of view on the stand-up, sit-down controversy comes from a nurse in Indianapolis, Ind.: "The R.N. is also a lady. If she rises, it should be only because she is, in a manner of speaking, a hostess in her own unit."

Many nurses reject Dr. Koontz' suggestion that they re-

NURSES REPLY TO CRITICISM

ceive too much education under the present system.

Says Julia Flores of Albuquerque, N. M.: "The better educated a nurse is, the better patient care she can give."

"Why," asks Margaret E. Rookard of Brooklyn, N. Y., "should the doctor resent the positive growth of the nursing profession?"

An R.N. from Randall, Iowa, says, "To suggest that a doctor or a nurse might be too well educated is, on the face of it, absurd."

On the opposite side of this argument is Beulah T. Marr of Stoneham, Mass., who says, "I wish schools of nursing would stop trying to turn out half-baked doctors. What we need is not more half doctors but more whole nurses. Nursing is, always has been, and always should be, an adjunct to medicine."

Not so, thinks Jeannette Justice of San Andreas, Calif., who says, "Nursing is no longer an ancillary profession. Nurses are no longer trained in obedience like prize dogs, but educated to an intelligent outlook that enables them to stand side by side and on a par with the rest of the medical team."

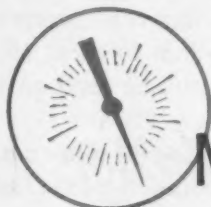
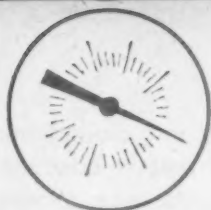
The nurse's economic plight is one sore spot laid bare by Dr. Koontz' statement that the modern nurse refuses to give service "above and beyond the call of duty."

Nelma Yancey of Noblesville, Ind., disagrees: "Too many people—you included, Dr. Koontz—still have the idea that nurses should serve humanity without compensation. *Your* oath is just as binding as ours, and *you* make a lot more money than we nurses do."

Even more personal in her thrust is a nurse from Plainfield, N. J.: "Could Dr. Koontz' wife live on a nurse's salary?"

A. Morris of Cleveland, Ohio, says, "The nurse is told that she is noble. But try to buy groceries with *that*!"

Pauline Easter of Houston, Tex., points out that Dr. Koontz' clock-watching scrub nurse just "doesn't have the latest model automobile waiting for her outside the hospital. If she fails to leave on the dot, she'll probably miss a bus that runs only every thirty minutes, from which she may have to transfer once or even twice before she can walk the rest of the way home at midnight." [More on 76]



By Clare Phillips, R.N.

A Fast Way to Measure Blood Loss

If at some time you see what looks like a stainless steel automatic washing machine in your O.R., better take a closer look. For it may be a Blood Loss Monitor.

A Blood Loss Monitor looks—and works—somewhat like the washing machine it resembles. But it is actually a device for quickly measuring the amount of blood a patient loses during an operation.

Surgeons cannot wait until sudden circulatory collapse discloses that a patient has lost more blood than he can spare. So, to estimate blood loss, they've had scrub nurses weigh

sponges and drapes; they've had lab technicians make fifteen-minute hemoglobin checks; they've even had the suction machine emptied to determine how much blood it contained.

But now there's a simpler, push-button method. The Blood Loss Monitor that makes this possible was conceived by Dr. Harry LeVeen of the Veterans

An O.R. technician makes sponge count before feeding blood-soaked material from the operative field into the electronic monitor.



A FAST WAY TO MEASURE BLOOD LOSS

Administration. Here's how his invention works:

In much the same way that an automatic agitator-type washer removes dirt from clothes, the monitor extracts blood electrolytes (charged particles of sodium, potassium, and other blood salts) from sponges, drapes, and drainage material.

In the resulting electrolyte solution, a pair of charged electrodes are positioned. The electric current passing between the electrodes activates the machine's blood-loss indicator.

The more blood-soaked ma-

terial you put into the machine, the more current is conducted and the higher the indicator rises. How many cubic centimeters of blood the patient has lost altogether can easily be read on its dial.

The Blood Loss Monitor can't distinguish between blood and other electrolytic solutions (e.g., normal saline and ascitic or pleural fluid). So Dr. LeVeene advises using a 2½ per cent glucose solution to moisten sponges and lap pads and a separate suction machine to drain off body fluids other than blood.

END

Strictly elective

The patient was lying docilely in bed awaiting his breakfast. He had received treatment for an infected toe and it was responding well. Suddenly an orderly and an uncapped student nurse marched into the room, hoisted him onto a stretcher, and without saying a word wheeled him to the elevator. "But Dr. Johnson didn't tell me he was going to have my leg X-rayed," he said.

"X-rayed?" said the orderly. "We're taking you to the operating room to have it amputated."

The poor man nearly fainted. That it was a case of mistaken identity never occurred to him. He thought the doctor had just been keeping the bad news from him. Finally the chief nurse came tearing down the corridor and got things straightened out.

But it took the staff a long time to forget. The patient was chairman of the hospital board.

—R.N., CONNECTICUT



**'DROP DEAD—
BUT DON'T
GET SICK!'**

That's what one nursing director said when a staff nurse asked about sick leave. And it's only one example, says this author, of what the surveys don't reveal about reasons for staff turnover

By Mildred Hale, R.N.

I don't need a survey to tell me why staff nurses often quit and go elsewhere. I *know* why—from sad experience.

Take RN's survey "Why Nurses Don't Stay Put" [May, 1958 issue]. It's described as being based on records in the files of nursing directors.

These records show each employee's stated reason for hav-

ing resigned. But is it the *real* reason?

You know the answer to that as well as I do. A nurse who resigns to escape an inconsiderate nursing director wouldn't *dare* put the truth on record. To do so would be to risk being black-balled from then on.

True, we don't *all* work for tyrants. But enough of us do so

THIS ARTICLE has won one of the 1958 Awards for its author. In order to express herself without restriction, she writes here under a pseudonym.

'DROP DEAD—BUT DON'T GET SICK!'

that job dissatisfaction and needless staff turnover are widespread.

Want some examples? Here are just a few from my own fifteen years' experience:

Take my present employer. When she hired me a year ago, she said I'd get eight holidays a year. But after I'd reported for duty, I found this notice on the bulletin board:

If a holiday falls on your second day off in a given week, the holiday and the day off will be considered as one.

So . . . ? So the director fixes the time-off schedule in such a way that we staff nurses lose one holiday after another.

Recently, one of our best nurses was stricken with bronchial pneumonia. It left her with a productive cough and an intermittent fever. Her doctor recommended an additional week's rest.

Could she get it? Not a chance. "You'll have to be on duty Monday as scheduled," the nursing director told her. "We're *too* busy to be short-handed."

"But the doctor says I'm too

sick to work," the R.N. objected.

"Look," the director replied. "You can drop dead—but don't get sick. I just can't rearrange the schedule every day."

As one of our nurses puts it, "She expects you to notify her today if you're going to be ill tomorrow!"

I'll admit that the job of director of nurses is no cinch. Adequate staffing is a problem in almost every hospital.

But there *is* such a thing as the Golden Rule. And I suspect that acting on it might, in the long run, make life happier for the nursing director as well as for her staff.

One director I worked under always arranged for her staff nurses to work the 11-7 shift preceding a scheduled two days off. This meant, of course, that much of the first day off was spent catching up on sleep lost the night before.

When the nurses went back on duty, moreover, it was always on the 7-3 shift. Often we were assigned to as many as three different shifts in a single week!

Still another director once persuaded me, much against my professional interest and personal wishes, to accept the 3-11

shift in the nursery with the understanding that she'd transfer me in three weeks to the 7-3 shift in the surgical ward. At the end of the three weeks, no transfer seemed to be forthcoming, so I asked her when she planned to reassign me.

"I've decided to keep you on the twilight shift," she said. "You and Miss Jones will alternate weekly between the maternity ward and the nursery."

As soon as I could afford to, I resigned. On my resignation, under "Reason for Leaving," I wrote the old cliché: "To accept a better-paying position." (This director's "Help Wanted" ad, by the way, is a daily feature in our local newspaper.)

Afraid of the Truth

So you see what I mean by surveys that don't reveal the whole truth. What else *could* I have written and still have avoided the risk of reprisal?

Reasons for resignations, given on the usual forms, are often so much whitewash. As long as this is so, no survey of official records can possibly reveal the real reasons behind today's excessive staff turnover.

No such survey shows, for

example, how often staff nurses must forgo outside interests because of poorly planned working schedules. Nor can studies of this kind disclose how many staff nurses are discontented in their jobs yet unable to quit because they have children to feed, house, and educate.

In sum, surveys get us nowhere in solving the costly and perplexing problem of staff turnover. This problem, in my opinion, is going to stay unsolved as long as nursing directors act like martinets instead of managers.

There are nine of us in our department—all mature and, I think, all genuinely dedicated nurses. We've discussed our working conditions often; and none of us is happy about them.

One scheme that occurs to us is that hospital administrators, who must struggle with the tremendous cost of staff turnover, try interviewing each departing nurse for a while, with a guarantee of no reprisal. They might learn a lot about the human relations side of the staffing problem.

As for me, I won't be at my present post when the next survey is made. I've just resigned—"to travel." END



R_v

DRUG TREATMENT OF T

Tuberculosis kills 16,000 Americans a year. Its annual world toll is close to five million. Most of the victims are infants or young adults between 15 and 35 years old.

Despite the statistics, we can take comfort from the fact that drugs discovered in the past decade have helped cut the tuberculosis death rate by 75 per cent. These drugs don't actually "cure" tuberculosis, but they do make medical treatment easier and lung surgery safer.

By keeping tubercle bacilli from growing and reproducing, such a drug gives the body's own

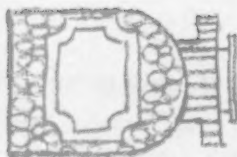
defenses a chance to curb the infection. But many months of drug treatment may be needed before the disease is brought under control. And, when used for long periods, the drug may cause toxic reactions.

The anti-TB drug may also stimulate the development of tougher strains of the germ. These strains are resistant to the drug; and as they grow and multiply, the patient may relapse.

Doctors have found they can minimize such disadvantages by giving two or more drugs in combination. This lessens the likelihood of side effects from each of

THE AUTHOR is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J.

OF TUBERCULOSIS



By Morton J. Rodman, PH.D

the drugs and also delays the development of drug-resistant germs.

To find out how good a drug is against tuberculosis takes about five years. It also takes that long to learn which combinations work best. So doctors can rate these drugs only over rather long periods of time.

Discovery of streptomycin in 1944 began the new era of tuberculosis treatment. The drug relieved patients doomed to die. It often controlled even conditions like tuberculous meningitis and miliary tuberculosis—which were almost 100 per cent fatal before streptomycin.

But streptomycin has its draw-

backs, too. For one thing, tubercle bacilli soon become resistant to it. Trying to meet this resistance by raising the dose only makes the patient dizzy and nauseated. It may also damage his auditory nerve so that he becomes deaf.

A derivative, dihydrostreptomycin, is said to be less toxic. It seems to make patients less dizzy and disoriented. But it may impair their hearing even worse than streptomycin.

Doctors have tried combining half-doses of the two drugs. They've hoped to get the full effect of each with only a fraction of the side effects of both.

This combination hits the

DRUG TREATMENT OF TUBERCULOSIS

germs all right. But it's apparently not much of an improvement as far as side effects go. People who get daily injections of the mixture still become groggy and deaf. And they run the risk of becoming allergic to both drugs at once.

Hazards to Nurses

For these reasons, some doctors use the dihydro derivative only when the patient becomes allergic to streptomycin. (Streptomycin allergy sometimes bothers the nurses who work with this antibiotic. They wear gloves, goggles, and face masks when handling it so as to avoid contact dermatitis and other allergic reactions.)

Just at the time streptomycin seemed to be losing its punch against tuberculosis, medical scientists made some discoveries that greatly increased its effectiveness. They found that two chemicals which had been sitting on their shelves for quite a while—isoniazid (INH) and para-aminosalicylic acid (PAS)—were tuberculostatic.

Now, as a result, germs that have grown immune to streptomycin can be controlled by combining INH or PAS or both with

the antibiotic. These chemicals attack tubercle bacilli in such a way as to help keep them from multiplying into whole new populations of streptomycin-insensitive germs.

Two Drugs Go Farther

What's more, the combination of INH or PAS with streptomycin needn't be injected every day. Less frequent shots hold down the level of antibiotic in body tissues and reduce the danger of severe side effects.

Tuberculosis germs destroy tissues, then hide out in the debris of dead cells. To reach them calls for a drug of high penetrating power. Isoniazid has this power.

Far better than most drugs, it gets at the hidden organisms. And it passes quite readily into the cerebrospinal fluid. So, when treating tuberculous meningitis with INH, there's no need to risk dangerous spinal injections.

Isoniazid sometimes reaches a high concentration in the kidneys. This makes it especially effective in renal tuberculosis. Only if the kidneys are too damaged to eliminate the drug is INH likely to pile up in the blood and brain and become toxic.

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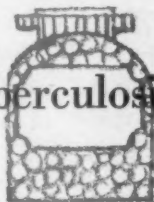
Isoniazid in normal doses has only slight side effects. Mouth dryness, constipation, and difficulty in emptying the urinary bladder are the main annoyances.

High doses, however, may

produce signs of central nervous stimulation, such as restlessness and hyperreflexia. Convulsions and even psychotic episodes have sometimes resulted.

Isoniazid overdose has been

Anti-Tuberculosis Drugs



Aldinamide (Pyrazinamide)
Aminosalicylic acid, U.S.P. (PAS, Pamisyl, Para-Pas, Parasal, et al.)
Amithiozone (Tibione, Conteben)
Calcium aminosalicylate, U.S.P. (Pasara Calcium)
Cycloserine, N.N.D. (Seromycin, Oxymycin)
Dihydrostreptomycin sulfate, U.S.P.
Iproniazid, N.N.D. (Marsilid)
Isoniazid, U.S.P. (Cotinazin, Nydrazid, Rimifon, et al.)
Kanamycin sulfate (Kantrex)
Neomycin sulfate, U.S.P. (Mycifradin)
Oxytetracycline HCl, U.S.P. (Terramycin)
Potassium aminosalicylate, N.N.D. (Parasal Potassium, Paskalium)
Sodium aminosalicylate, U.S.P. (Pamisyl Sodium, Para-Pas Sodium, Pasem Sodium, Pasmed Sodium, et al.)
Streptomycin sulfate, U.S.P.
Streptomycin isonicotinyl hydrazine sulfate (Streptohydrazid)
Viomycin sulfate, N.N.D. (Vinactane, Viocin)

DRUG TREATMENT OF TUBERCULOSIS

known to cause peripheral neuritis. The extremities tingle, burn, and become numb or painful. But none of these symptoms develops when pyridoxine (vitamin B₆) is given along with the INH.

Isoniazid and streptomycin are by far the most potent tuberculostatic drugs. But para-aminosalicylic acid is important in another way: It helps prevent the development of tubercle bacilli that will resist the harder-hitting drugs.

Patients Don't Like It

The drawback of PAS is that it has to be given in high oral doses. This irritates the gastrointestinal tract and can cause nausea, vomiting, and loss of appetite. Because of this, certain patients balk at taking PAS. So doctors are seeking some other secondary drug to supplement streptomycin and isoniazid.

Recently, a number of such compounds have been introduced and are being clinically tested. But it will be some time before we know just where they fit into the tuberculosis-treatment picture.

Among the most promising of these on-trial agents are the anti-

biotics kanamycin (Kantrex) and cycloserine (Seromycin). Neither is yet recommended for treating newly diagnosed cases. They're best held in reserve against germs resistant to the better-established drugs.

Sometimes strikingly effective is the new synthetic compound aldinamide (Pyrazinamide). But since it may cause hepatitis, it's indicated mainly for patients who fail to respond to the other tuberculostatic drugs. In such desperate cases, the possibility of liver damage may be well worth risking.

Drugs really effective against tuberculosis are hard to discover and to evaluate. But the search still goes on for a chemical capable of wiping out the world's most widespread infectious disease.

Some day, perhaps, we may find the ideal chemotherapeutic weapon, the long-sought "magic bullet": a harmless chemical that will seek out and destroy tubercle bacilli anywhere in the body. Meanwhile, much can be done by early diagnosis of tuberculosis and by making the best possible use of our present drugs as supplements to other standard treatment.

END



Lifeline in a Storm at Sea

BY IRENE M. LEE, R.N.

My father shook his head:

"No, Irene. It won't be worth it. You'll be in training for three years—and then what? You'll probably get married. And all that preparation will be wasted."

Despite his warning, I went into training. And not long after I became an R.N. I got married as he said I would. By the time the children arrived, it certainly looked as if Father had been right.

But now I know he couldn't have been more wrong. For in times of stress my training has been like a lifeline in a storm at sea. No other form of education, I'm sure, could have prepared me so well for the problems of which life in this generation is compounded.

In training, we acquire more than just nursing knowledge. We learn to accept responsibility—to act quickly and calmly in emergencies. Being able to do this has helped me to meet many a family crisis successfully.

My OB and pediatric courses have, of course, proved invaluable to me in the bearing and rear-

THIS ARTICLE has won one of the 1958 RN Awards for its author, a part-time nurse in Merchantville, N. J.

SEBACEOUS ACTIVITY AS RELATED TO HEALTH AND COSMETOLOGY

Dermatologic Research for Improved Cosmetology Today, scientific principles are essential in formulating cosmetic products. Many new synthetic compounds and procedures have been developed. But controlled research has not kept pace with these advances. "The need for increasing the scope and number of investigations relating to fundamental problems of skin physiology, biochemistry, pharmacology, and toxicology cannot be stressed too strongly."¹

Much remains to be learned of the relationship between sebaceous gland activity and the cosmetic care of the skin. Confusion exists among physicians, pharmacologists and cosmetic chemists concerning the use and properties of a skin emollient²—which may be defined as "...externally applied material that tends to prevent or counteract the symptoms and signs of dryness of the skin."² The emollient preparations of the cosmetologist and the topical prescriptions of the physician have much in common.²

The Sebaceous Glands... Key Factors Sebum, the excretory product of the sebaceous glands, forms a film which diffuses all over the skin's surface and penetrates between the horny lamellae of the stratum disjunctum.³ This film protects against abrupt temperature and humidity changes,³ and helps to maintain the normal resiliency and hydration of the horny layer.⁴

Distribution of the Sebaceous Glands Sebaceous glands cover the body surface with the exception of the palm and the sole and dorsum of the foot.⁵ They are found in great abundance—approximately 400 to 900 per sq. cm.—on the scalp, forehead, face and chest over the rest of the body—in quantities that average less than 100 per sq. cm.⁵

Structure and Cellular Morphology The sebaceous glands are acinar, holocrine glands. Mitosis originates from the outermost germinative cells of the gland and proceeds through successive layers in a continuous stream of oil-forming cells toward the center. During the movement, cells grow larger with an accumulation of fat droplets. Finally, fat distension within cells becomes so great that cell walls disintegrate with the liberation of lipid.⁴ Histochemical studies^{7,8} show phospholipids in the matrix cells of the acini and their gradual disappearance with increased lipid infiltration. This transformation has been linked with mitochondrial filaments and Golgi elements.^{9,9} Immature cells contain glycogen.¹⁰ Succinate dehydrogenase,¹¹ alkaline phosphatase,¹² and nonspecific esterases¹³ have been noted.

Mechanism of Sebum Excretion and Distribution Three factors chiefly regulate sebum flow to the skin surface—(1) number of glands in a unit area; (2) skin temperature and (3) emulsifying action of sweat.⁴ Starting with a defatted surface, excretion sets in rapidly. When the surface layer reaches a thickness sufficient to counteract the glandular force, expulsion stops.^{14,15} With subsequent defatting, excretion is resumed.^{14,15} A recent report disputes this "feedback" concept claiming that "...the sebaceous gland functions continuously, without regard to what is on the surface."¹⁶ High temperatures keep the film liquid at low temperatures, sebum solidifies and counteracts glandular excretion at lower levels. Sweat secretion emulsifies sebum and facilitates its spread.¹⁸ The tremendous effect of sweating on spreading of the film has been shown.¹⁸ Regional differences in sebum secretion are paralleled by corresponding changes in sweat delivery.¹⁹

Chemical Composition of the Skin Surface Film The surface film is a complex mixture of fatty acids and their cholesterol esters, wax alcohols, glycerol, free cholesterol and hydrocarbons—notably squalene.²⁰ Free fatty acids apparently contribute to the antipathogenic²¹ and "self-sterilizing"²² character of the film. The wax alcohols and cholesterol

ALSO CARE OF NORMAL AND AGING SKIN

principles and emulsifiers. Squalene is typical of human fat while its chemical counterpart, lanosterol, is peculiar to the sheep. Horse sebum bears the closest known relationship to human sebum.² The following commercial claims made for lanolin in this respect.

Influence of Sex Hormones on Sebaceous Activity Sebum secretion rises sharply at puberty.²³ It then levels off, becoming constant at about 25.²⁴ In old age there is a decrease of sebaceous activity in women.^{25,26} Sex hormone factors are critical for the regulation and development of sebaceous gland activity. "Progesterone definitely stimulates sebaceous gland growth,"²⁷ by increasing the number of sebaceous cells.⁴ A pituitary factor, prolactin, appears to be essential for the maintenance of the sebaceous glands and for their normal response to stimulation by the sex hormones.²⁷

Clinical Management of the Skin as Related to Its Sebaceous Activity The new scientific soaps and detergents have proved useful for needed day-to-day removal of excess sebum as seen in seborrheic and greasy skins. Dryness responds to suitable emollients which act on the skin surface to help guard against undue moisture loss. "An effective emollient must be constituted that it will help the stratum corneum maintain an adequate water content."²⁸ In aging skin the problem is to help the skin by stimulating lost sebaceous function. Progesterone applied topically increases the surface emolliency of dry, aging female skins as shown by *in vivo* staining of unsaturated fats at inunction sites and in tissue sections.²⁸

Beauty Through Science At the Helena Rubinstein Laboratories, the application of established dermatologic principles to scientific cosmetology has resulted in preparations that provide benefits far beyond mere adornment. Of special importance to the maturing woman has been the development of Helena Rubinstein's Ultra Feminine Face Cream... the culmination of 30 years' intensive dermatologic, endocrinologic and cosmetologic research through the topical effect of combined estrogens and progesterone on aging skin. Clinical studies indicate that such therapy can help the patient maintain her youthful skin tone well into "middle age."

References: (1) Lehman, A. J.: J.A.M.A. 164:416 (May 25) 1957. (2) Blank, I. H.: J.A.M.A. 164:412 (May 25) 1957. (3) Rothman, S.: Physiology and Biochemistry of the Skin, Chicago, University of Chicago Press, 1954, p. 310. (4) Lorincz, A. L., and Stoughton, R. B.: Physiol. Rev. 38:481, 1958. (5) Montagna, W.: Structure and Function of Skin, New York, Academic Press, Inc., 1956, pp. 255-257. (6) Lobitz, W. C., J.A.M.A. Arch. Dermat. 76:162, 1957. (7) Montagna, W.; Noback, C. R., and Zak, F. G.: Am. J. Anat. 49, 1948. (8) Suskind, R. R.: J. Invest. Dermat. 17:37, 1951. (9) Montagna, W.: *loc. cit.*, ref. 5, pp. 275-277. (10) Montagna, W.: *loc. cit.*, ref. 5, p. 275. (11) Montagna, W.: *loc. cit.*, ref. 5, p. 277. (12) Bourne, G. E.: Quart. J. Exper. Physiol. 32:1, 1943. (13) Montagna, W.: J. Biophys. & Biochem. Cytol. 1:13, 1955. (14) Schur, H., and Goldfarb, L.: Wien klin. Wchnschr. 40:1255, 1927. (15) Emanuel, S.: Acta dermat.-venereol. 19:1, 1938. (16) Kligman, A. M., and Shelley, W. B.: J. Invest. Dermat. 30:99, 1958. (17) Rothman, S.: *loc. cit.*, p. 291. (18) Jones, K. K.; Spencer, M. C., and Sanchez, S. A.: J. Invest. Dermat. 17:213, 1951. (19) Herrmann, F.; Prose, P. H., and Sulzberger, M. B.: J. Invest. Dermat. 18:71, 1952. (20) Rothman, S.: *loc. cit.*, p. 312. (21) Peck, S. M.; Rosenfeld, H.; Liefer, W., and Bierman, W.: A.M.A. Arch. Dermat. & Syph. 39:126, 1939. (22) Burtenshaw, J. M. L.: Brit. M. Bull. 3:161, 1945. (23) Rothman, S.: *loc. cit.*, p. 295. (24) Kligman, A. M., and Ginsberg, D.: J. Invest. Dermat. 14:345, 1950. (25) Kirk, E.: J. Gerontol. 3:251, 1948. (26) Traub, E. F., and Spoor, H. J.: J. Am. Geriatrics Soc. 1:805, 1953. (27) Lorincz, A. L., and Spoor, H. J.: Science 126:124, 1957. (28) Spoor, H. J.: Proc. Scientific Section, Toilet Goods Association, 1957:1 (May) 1957. (29) Clinical Research Division, Helena Rubinstein, Inc.

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LIFELINE IN A STORM

ing of children. Often, I've forestalled serious illness in our youngsters simply by being able to spot the early symptoms of childhood diseases.

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More important, it's my economic security card. My husband and I enjoy a real sense of protection in knowing that I could, if necessary, earn enough at nursing to see us through a financial crisis.

Meanwhile, part-time duty keeps me active and assures me that life isn't passing me by.

When my children are grown, I'll resume full-time duty and perhaps take post-graduate work. In that way, I'll be self-supporting—and too busy to meddle in my children's lives.

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Skin Grafting for Burns

Continued from 35

bleeding and break down the existing tissue barrier to invasive infection.)

If the eschar is held to the underlying tissue by only a few bands of collagenous tissue, she cuts these with sterile scissors. Then she applies fresh gauze pads that have been soaked in warm, sterile saline.

A very large dressing can be so painful to the patient when it's changed that it may have to be kept in place for much longer

than four hours. In that event, you incorporate several sterile catheters in the dressing and drip saline through them as necessary. (This is a messy procedure, so be sure to protect the bed linen with a rubber sheet.)

The entire dressing must in any event be changed at least once a day. Otherwise, when you introduce the saline, you wash exuded pus into the wound.

The quickest and most desirable way of removing the eschar is by surgical excision. But it's appropriate only for patients in top physical shape.

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As soon as such a patient's eschar begins to soften, he's taken to the O.R. and put under general anesthesia. The dead tissue is cut away, subcutaneous bleeders are tied off, and a dressing is applied.

The Latest Method

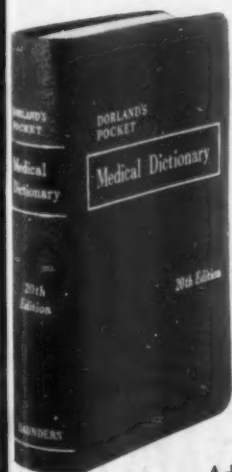
A new technique, still in its infancy and requiring an extremely skilled surgical team, is *immediate* excision of the eschar—within a day or two after the burn occurs. Since it's difficult to distinguish the eschar this early, everything is removed, right

down to the fascia. Then a dressing is applied, and three or four days later the surface is ready for skin grafting.

Once the eschar is removed—regardless of the method—a clean, well-granulated surface is needed on which the permanent skin grafts will "take." There are several means to this end—several ways to protect the exposed surface until it is ready to receive grafts. These include dry sterile dressings, warm saline soaks, application of antibiotic gauze, and covering with homografts. *More▶*

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SKIN GRAFTING FOR BURNS

Dry dressings and saline soaks, applied the same way as for eschar removal, keep the wound clean and permit frequent checks on the progress of granulation. The surface is ready to receive the grafts just as soon as it appears to be flat, red, and granulating.

Timing Is Important

Any delay beyond this point will let the granulating tissue pile up in soft heaps that can prevent a graft from "taking" properly. So it's important for the nurse who changes the dressings to in-

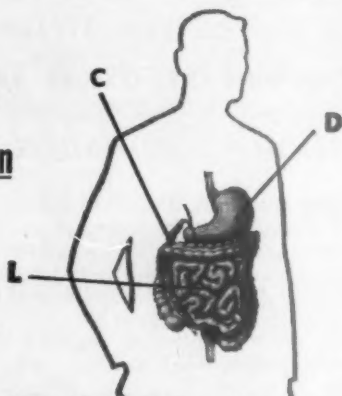
spect the surface carefully and to report its condition accurately to the doctor.

Antibiotic gauze is used for very dirty burn wounds, especially when wound cultures show the presence of group A beta hemolytic streptococci on the granulating surface. (Grafts take poorly if these microorganisms are present.)

Though antibiotic gauze is available commercially, you can prepare it yourself, like this: Using sterile technique, open a roll of sterile gauze bandage, apply the prescribed antibiotic oint-

relieve
the symptoms
of constipation

headache
malaise
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treat
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faulty digestion
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poor muscle tone
irregularity

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ment with a tongue blade, and roll up the bandage again. In a matter of seconds, the ointment will have thoroughly impregnated the gauze and it will be ready for application to the wound surface. This dressing must be changed every forty-eight hours.

Placental membranes are sometimes used as a temporary burn dressing. But they're difficult to handle, and it's doubtful that the results are good enough to justify the time and effort they take. If they're used in your hospital, it's wise to make arrange-

ments with the delivery room nurses to have the membranes ready as soon as possible after delivery.

Placental membranes are obtained in the course of either normal or Caesarean deliveries. The mother must, of course, be free of communicable, skin, and neoplastic diseases.

Under sterile conditions, the amnion and chorion, still adherent to each other, are cut away from the fresh placenta, rinsed in sterile saline solution, and wrapped in sterile gauze. Covered and stored at 1 to 4 de-

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SKIN GRAFT OR BURN

grees C., they can be preserved
for several weeks.

When they're to be used as a
burn dressing, the preserved
membranes are first heated in
warm, sterile, saline solution.
Then the amnion and chorion
are separated and laid on the
wound, adherent surface down.
They can be sutured to the
wound edges or held in place
with dressings. Since they dry
and crack after a few days, they
have to be renewed frequently.

Homografts—i.e., strips of
skin from a donor or a fresh
cadaver—are the best temporary

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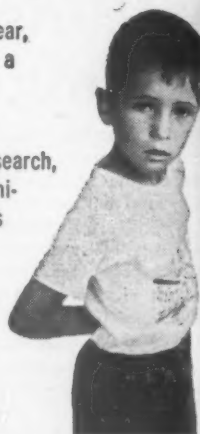
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TOR BURNS

burn dressing. But they're not easy to get.

Applied the same way as placental membranes, they have the advantage of lasting much longer—about four weeks. When they slough off, the surface is ready for grafting. END

EDITORS' NOTE: *This is the first portion of a two-part article on skin grafting for burns. In the concluding portion, Dr. Artz will describe how skin is removed from the donor site, how it is applied to the burn wound, and the nurse's role in both instances.*

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Why Not National Licensure?

Continued from 39

With this voluntary principle in mind, the American Nurses Association set up in 1943 what is now called its Special Committee on State Boards of Nursing. Its subcommittees deserve much of the credit for improvements made so far in interstate licensure.

But the goal has not yet been reached. And it won't be reached without a lot of hard organizational work. To illustrate:

State nurse practice acts need to be improved radically. Today only about one-third of the jurisdictions have a so-called mandatory licensing law that defines who is qualified to practice and that requires a license of those who do. The rest have statutes that, for the most part, merely protect the public from misrepresentation by unqualified persons (e.g., use of the title R.N. by persons who have not been licensed to use it).

In 1957 the A.N.A. forged a tool called "The Statement of Functions, Standards and Quali-

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fications for Practice." It specifically defines these things as they apply to the nurse in general duty, private duty, nursing service, and nursing education. Already it has been used as a guide in remodeling current nurse-practice acts.

Another thing:

Although requirements for licensure may not (and probably shouldn't) be standardized nationally, existing differences in *minimum* requirements are probably wide enough to cause certain problems.

Not long ago, *RN* sampled the

nursing-curriculum requirements of a cross-section of twenty-four states. Here are some of the findings:

¶ Only eleven states specify the minimum over-all length of a nursing education.

¶ The minimum number of hours of classroom instruction varies all the way from 700 in Illinois to 1,200 in Florida.

¶ The minimum period of clinical practice ranges from as little as ninety weeks in New York to 108 weeks in California.

¶ A specific number of surgical scrubs and experiences in ob-

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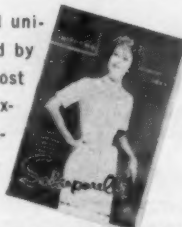
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WHY NOT NATIONAL

stetrical delivery is required by only three states.

¶ All except eleven of the jurisdictions have minimum age and citizenship requirements; but they vary considerably.* In Utah, for example, a license may be granted at age 18; in North Dakota, not until 21.

State boards are assuming more responsibility than ever before in helping the schools to develop educational standards. The schools are also guided—on a voluntary basis—by the accrediting service of the National League for Nursing.

In 1956, of the 1,115 legally authorized schools of nursing, 906 had either full or partial N.L.N. approval.* R. Louise McManus, director of nursing education at Teachers College, Columbia University, says the nursing profession, like the medical profession, must decide about discontinuing nonaccredited schools.

The inadequacy of some of the agencies set up within the states to administer licensure laws is another sore spot. Every state and territory has its board of nursing; but membership and authority vary widely.

Only half the jurisdictions have

*The source of this and other asterisked material in this article is the American Nurses Association.

INSURE?

ards composed solely of registered nurses. The rest include physicians, hospital administrators, educators, even practical nurses—all of whom may act on matters concerning the professional nurse.

A Positive Program

If the problems of licensure are to be solved properly, nurses themselves will have to come up with some of the answers. Since national licensure is impossible, it seems that we may well start working toward these goals:

¶ Establishment of a program of professional lobbying for stronger legislation.

¶ Wider use among state boards of the voluntary-agreement principle in interstate licensure.

¶ Reorganization of state boards to the end that they may be composed of R.N.s and vested with adequate authority.

These goals are the kind achieved by collective effort, through our professional nursing organizations. But an organization is no more effective than the individuals in it—yourself, for instance.

So find out how *you* can help. Then lend a hand. Improvement of nursing licensure is one job in which we all have a stake. END

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What Nurses Say Has Happened to Nursing

Continued from 50

Danna Barnes of Ionia, Mich., says: "I love nursing, but gratitude won't buy necessities."

RN received far more replies to Dr. Koontz' article from male nurses than could statistically be expected from the ratio of men to women in the profession. And they were uniformly critical of the doctor's views.

Their position is expressed by Morris A. Wolf of Brooklyn, N. Y., who says, "I'd advise Dr. Koontz to dig a little deeper, to examine causes as well as effects. Nurses are becoming, morally and legally, ever more responsible for their actions as the scope and depth of their work increases. They are no longer ancillaries who snap to attention at the sight of the doctor and exist only to obey his bidding."

Even some husbands of nurses have joined in the rebuttal. William V. Kennedy of Camp Hill, Pa., states their case:

"While doctors have been pulling down fees that in some instances have approached a national scandal, they've made little or no effort to better the

substandard wages and working conditions of the nurse. I suggest that Dr. Koontz and his fellows look to themselves for the reasons that have driven competent nurses out of the profession and tried to the limit the sense of duty of those who remain."

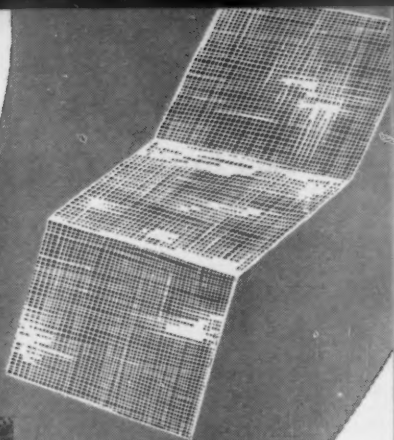
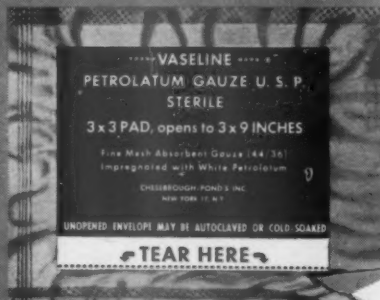
RN readers agree emphatically with Dr. Koontz that good patient care is the number-one responsibility of all members of the healing art. F. Owings of Los Angeles, Calif., puts the thought in these words:

"There is no argument that the care of the patient is the reason for the existence of hospitals, nurses, and doctors. They should be one team, working together for the best possible results. Until doctors can accept nurses as partners on this team, instead of considering them menial employees, it will be impossible to establish effective working conditions."

The middle-of-the-road view is summed up by Margaret E. Rookard of Brooklyn, N. Y.:

"Nursing at long last is becoming a true profession. Many of the problems Dr. Koontz mentions could be solved in short order if today's doctors would recognize that this is 1959!" **END**

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**3" x 9"
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Shorter length ends waste
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Guaranteed sterile at time of use.

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Professional Products Division

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How to Help Teen-Agers With Acne

Continued from 44

Adolescent Unit stress the value to their young patients of rest, outdoor exercise, a daily bath, a balanced diet, and a scalp free from dandruff. They teach the boys and girls how to care for their hair and nails as well as their skin. And they point out the importance of clean clothing and bed linen.

Since untreated acne can lead to scarring, the Unit's staff gives special attention to even the mildest case. Despite recent advances in techniques, scar removal can benefit only about two in five patients. So scars, which can cause serious difficulty in finding jobs and mates, tend to be permanent with about 60 per cent of young patients seen.

For those with really severe

cases of acne, the doctors have a battery of treatments for controlling infection and minimizing scar formation. These treatments include antibiotics; staphylococcus vaccine; vitamin A, hormone, and X-ray therapy; and ultraviolet irradiation.

Antibiotics are given orally, usually for a maximum of ten days. Oral sulfa drugs are also used.

Staphylococcus vaccine is given intracutaneously in gradually increased doses once or twice a week for a total of from ten to twenty doses. If necessary, this course may be repeated—often after an interval of from four to six weeks.

Vitamin A in large oral doses sometimes prevents an excess of keratin at the mouths of the sebaceous glands. When it does, it also helps to reduce scar formation.

More►



Have you heard about **ROMILAR** for cough?

It's not a narcotic—yet its specific cough-calming effect is equal, if not superior, to that of codeine... and it doesn't have codeine's side effects. No constipation or nausea, no drowsiness, no tendency to addiction. Romilar comes as syrup, tablet, or expectorant (with ammonium chloride). Prescription not required.

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UTENSIL WASHER-SANITIZER



Protects patients and personnel against cross contamination - - dependably and at less cost.

Prevention of cross contamination from patient utensils is accomplished rapidly, automatically and at reduced cost with the new American Utensil Washer-Sanitizer. The powerful detergent wash, double rinse and steaming cycles are completed in 22½ minutes . . . with no attention from nursing personnel other than loading and unloading. Three sets of utensils are processed in two loads.

The American Utensil Washer-Sanitizer is economical to install and pleasant for nursing personnel to use. It assures uniformly high standards of cleaning and sanitizing by eliminating the possibility of human error . . . and, its modest cost is more than justified by the saving in personnel time alone.



The American Utensil Washer-Sanitizer is available with clean-up counter or as the free-standing unit shown above.

For complete information on this improved utensil technique, write for bulletin SC-321-R.



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related hospital equipment*

HOW TO HELP TEEN-AGERS WITH ACNE

Estrogenic hormones may be of value in counteracting the effects of increased androgen in the body. But they tend to cause enlargement of the breast in boys and to affect ovarian activity in girls. So they are rarely used; and even then only under careful supervision. Some doctors restrict the use of estrogenic hormones to females and give them only during the last half of the menstrual cycle.

X-ray therapy, also reserved for extreme cases, is given only by a qualified specialist.

Ultraviolet irradiation acts

much the way sunlight does: The skin dries and scales, which helps prevent the pores from becoming clogged and infected. Here is the ultraviolet procedure:

The patient's eyes are protected with moist cotton and the affected areas exposed to the lamp at a distance of about fifteen inches. Exposure time is one minute the first day, one minute and thirty seconds the next, increasing daily thereafter by half a minute till a maximum of ten minutes is reached.

The Adolescent Unit suggests dermabrasion and other scar-re-

PROTECT Little Braves' Bottoms



"DIAPARENE PERI-ANAL is an efficient and safe agent in the prevention and treatment of perianal dermatitis"* . . . newborn "sore-bottom" due to loose, transitional stools and irritations caused by diarrhea or loose stools following oral antibiotic therapy.

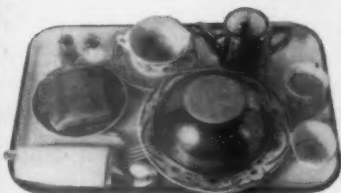
*Grossman, Leo, "A New Specific Treatment for Perianal Dermatitis", *Arch. Ped.*, 71:173-79, June, 1955

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Or prescribe convenient, delicious **VITERRA Pediatric** in the unique new Metered-Flow bottle.

Dosage: usually one capsule or Tastitab daily.

Supplied: CAPSULES: in 30's and 100's.

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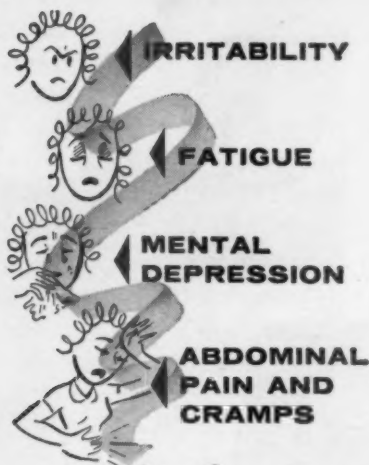
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HOW TO HELP WITH ACNE

moving techniques only sparingly—never for a teen-ager who has active acne. And it must always be done by an experienced specialist.

With proper treatment, acne will leave hardly any scars. That's one reason why the doctors at Children's Hospital put such stress on treating even mild cases. Both the physical scarring of acne and the emotional scarring can be prevented, they emphasize.

Where to Send Them

"These boys and girls need a place to go where they can find people who'll take a real interest in their skin troubles instead of ignoring them," says the Adolescent Unit's head nurse. "If there's no adolescent clinic nearby, we ought to see that they go to a dermatologist or a dermatology clinic. But the most important thing we nurses can do for teen-agers with acne is take them seriously.

"Teen-age boys and girls are trying hard to understand themselves. They don't want to be 'different' or left out of things. A nurse is in a wonderful position to give them the kind of guidance and help that will see them safely through this most difficult time of their lives."

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Who?
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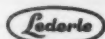
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AUTRINIC® Intrinsic	1 U.S.P.	2 U.S.P.	2/3 U.S.P.
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Ferrous Fumarate	271 mg.	350 mg.	168 mg.
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news

Continued from 28

Dr. Tompkins believes lollipops can often prevent or lessen the five major symptoms of childhood illness: vomiting, hyperventilation, fever, diarrhea, and convulsions. "With a sick child," he says, "refined sugar is used not as a food but as a medicine. We can often prevent the whole train of symptoms by giving the sugar to him promptly."

Dr. Tompkins also recommends giving lollipops and soda the night before a child is scheduled for surgery and the next morning as well.

With such a routine, he says, the child's liver is protected during the long period without food; and when so protected, the child rarely vomits during or after anesthesia.

Oxytetracycline Found Best for Newborn Eyes

Both silver nitrate and penicillin are obsolete for preventing ophthalmia neonatorum. So says a recent report in the *Journal of Diseases of Children*. A study of 1,139 infants, made by Dr. P. L. Mathieu Jr. of Providence, R.I., indicates that oxytetracycline is the safer and more effective drug.

Dr. Mathieu says oxytetracy-

On our floor

WHY THAT'S THE ARTIFICIAL KIDNEY WE SAW IN THE MOVIE THE OTHER DAY!

YES, THAT'S THE PERMANENT PUMP-TANK UNIT WHICH HOLDS THE COIL FOR HEMODIALYSIS.

...AND THAT'S THE DISPOSABLE TWIN COIL WHICH FUNCTIONS FOR THE PATIENT'S KIDNEY DURING CORRECTIVE THERAPY.

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cline is of value not only against the gonococcus but also against other organisms responsible for neonatal conjunctivitis. He calls it less irritating than silver nitrate and unlikely to produce the sensitization reactions often caused by penicillin.

One instance of acute eye infection occurred during the study. It was caused by pneumococcic organisms and occurred in a baby treated by silver nitrate alone.

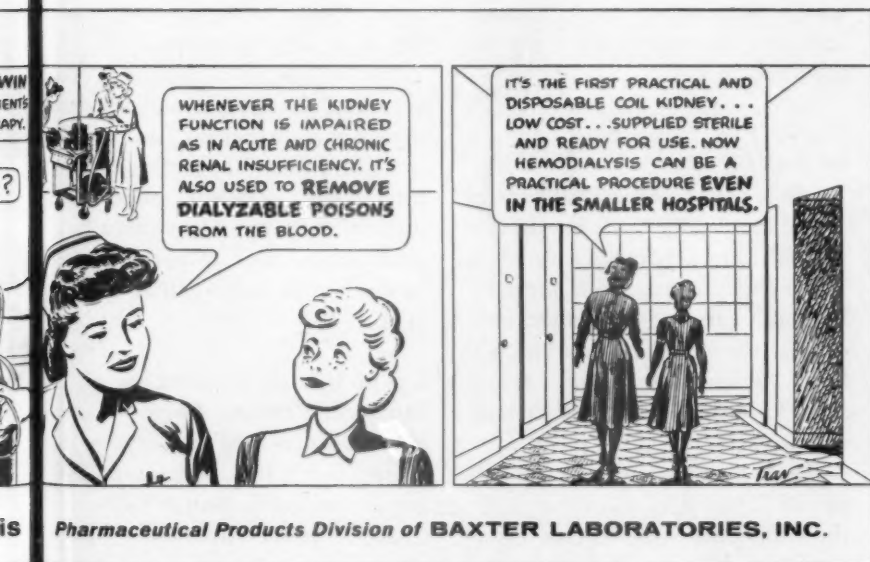
Penicillin Deaths in the U.S. had reached the 1,000 mark by 1957, says the World Health Organization. It urges that sale and

use of the drug be M.D.-controlled. Three shots in every 10,000,000 may be fatal, it adds.

New Oral Antidiabetic Said to Be Effective

Chlorpropamide (Diabinese), a new oral drug for the control of diabetes, is "at least twice as powerful as any other such agent now available," says the New York Academy of Sciences. As partial evidence the academy reports:

¶ A study by University of Oklahoma clinicians, indicating that chlorpropamide remains in the blood stream for seventy-two hours after a single dose and that it low-



WHENEVER THE KIDNEY FUNCTION IS IMPAIRED AS IN ACUTE AND CHRONIC RENAL INSUFFICIENCY, IT'S ALSO USED TO REMOVE DIALYZABLE POISONS FROM THE BLOOD.

IT'S THE FIRST PRACTICAL AND DISPOSABLE COIL KIDNEY... LOW COST... SUPPLIED STERILE AND READY FOR USE. NOW HEMODIALYSIS CAN BE A PRACTICAL PROCEDURE EVEN IN THE SMALLER HOSPITALS.

Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

news

ers blood-sugar levels faster than tolbutamide.

¶ A study by Dr. Zeb L. Burrell Jr. and associates at Milledgeville (Ga.) State Hospital, showing effective control of diabetes by chlorpropamide alone in 108 of 130 adult cases over a period of a year.

¶ A study by Dr. Garfield G. Duncan of the University of Pennsylvania, indicating no side effects requiring discontinuance of the drug in any of fourteen closely observed hospital patients.

Burr Holes are being filled with a mixture of bone dust and penicillin solution that hardens into a substance resembling normal cranial bone. Russian scientists who devised the technique say they've tried it successfully on 56 animals and may eventually try it on human beings.

Nurse Pay Studied In California

Average pay of general duty nurses in California is \$354 a month. Industrial nurses there average \$404; nursing educators, \$450; and public health nurses, \$459. Office nurses, with the lowest average (\$351), have the broadest range, varying from \$225 to \$700 a month in individual cases.

These figures result from a survey of 2,100 R.N.s, conducted by the California State Nurses' Asso-

ciation. The survey also shows that the average pay of hospital nurses is highest in tax-supported institutions—Federal, state, and county, in that order. It's lowest, oddly enough, in hospitals operated privately for profit, and next lowest in private nonprofit establishments.

Poll Shows What Public Thinks of Hospitals

Nearly 40 per cent of the American people think hospital charges are "much too high"; another 31 per cent think they're "somewhat high"; and only 21 per cent think they're "about right."

So says the Health Information Foundation after a nation-wide survey made in cooperation with the University of Chicago's National Opinion Research Center. The study also shows that:

¶ Some 66 per cent consider local hospital facilities and services to be either "excellent" or "good."

¶ More than 70 per cent can recall from personal experience something they've liked about hospital service; and 46 per cent can remember something they've disliked.

Up-to-Minute Report on Surgical-Patient Care

New concepts and procedures for dealing with the surgical patient were reported at the 1958 Clinical Congress of the American College

the CLINIC

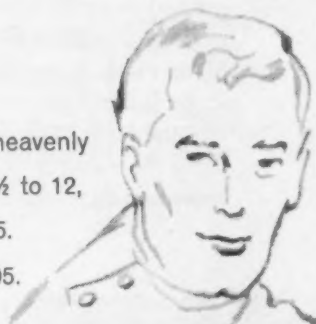
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You deserve a shoe that looks wonderful, feels heavenly
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The Clinic Shoemakers, Dept. RN-1, 1221 Locust St., St. Louis 3, Mo.

news

of Surgeons. Here are some of the exciting new developments heard and discussed by the 7,000 doctors who attended the meetings:

¶ A "first-aid" version of the heart-lung machine was introduced by a group of surgeons from Tulane University. The tiny pump-oxygenator has sterile components that are packaged ready for use and can be assembled in about ten minutes. Extracorporeal circulation can be established within thirty minutes, according to the surgeons, even under most unfavorable circumstances. The machine is expected to be capable of taking over the circulation temporarily in such emergencies as pulmonary embolism, coronary occlusion, and cardiac arrest.

¶ A major drawback in some heart-lung machines is that embolism may be caused by microscopic oxygen bubbles remaining in the blood when it has been purified by bubbling oxygen through it. To overcome this hazard, a New York University group has invented a bubble monitor. This they described as an airtight chamber that permits direct observation of the blood with a high-power microscope just before it is shunted back into the body. The group has been using the monitor to check the efficiency of the bubble-removing de-

vices in various heart-lung machines now in use.

¶ Two methods of dealing with hydrocephalus in infants were presented. A Bellevue Hospital group described draining the excess cerebrospinal fluid into a reservoir constructed by anastomosing a segment of the small intestine to the lumbar subarachnoid space. The intestinal mucosa absorbs the C.S.F. as rapidly as it is formed. The other method—still experimental—presented by members of the Medical College of Georgia, is to attach polyethylene tubing to the right ventricle of the brain and drain the excess C.S.F. into the gallbladder.

¶ A New York obstetrician reported that Pitocin can be absorbed via the buccal membrane and may eventually provide a safe, simple method of inducing labor. Pitocin linguets stimulated milk secretion, he said, and produced uterine contractions. The contractions were similar to but less efficient than those produced by parenteral administration of the hormone. Absorption time was about thirty minutes, and the average dosage required was at least ten times the standard amounts for I.V. and I.M. administration. In this technique, the patient holds the Pitocin linguet between the gums and

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SKIN SPECIALISTS EXPLAIN WHY
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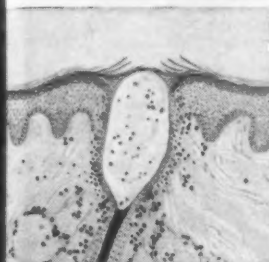
Open and Dry Pimples

to clear them fast, safely

Skin Specialists agree that, to be truly effective, medication for pimples and acne should provide these two actions: (1) 'Keratolytic' action to open affected skin tissue, permit penetration, encourage quick growth of new skin. (2) Fast-drying

action to help remove excess oil that can clog pores and cause pimples. In tubes or new, squeeze-bottle lotion, CLEARASIL provides the effective medications prescribed by leading Skin Specialists, and clinical tests prove it *really works*.

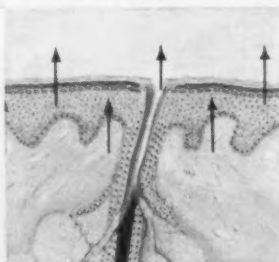
How Clearasil Works Fast to Restore Clear, Smooth Skin



Opens Pimples Medically. CLEARASIL's "Keratolytic" action gently dissolves and opens hard, affected pimple "cap" *medically*, to relieve inflammation. Squeezing can cause infection, or drive it deeper ... may result in scars.



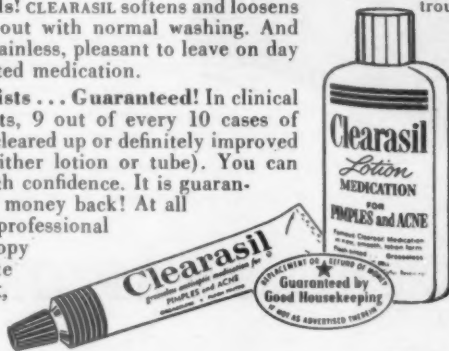
Antiseptic Medication Penetrates. As the pimple opens, CLEARASIL's antiseptic medication penetrates to any lower infection ... stops growth of bacteria in and around pimple, helps prevent further pimple outbreaks.



Dries Up Pimples Fast. CLEARASIL is not just greaseless, but is actually oil absorbing, and works to remove excess oil in pores that helps pimples grow and thrive. Oily skin creams and ointments can actually "feed" pimples. Even so-called greaseless creams fail to dry up trouble-causing oils.

"Floats" Out Blackheads! CLEARASIL softens and loosens blackheads so they float out with normal washing. And CLEARASIL is greaseless, stainless, pleasant to leave on day and night for uninterrupted medication.

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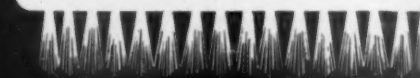
cheek, allowing it to melt. She simply spits it out when contractions begin. Slow absorption via the transbuccal route acts as a safety factor. Further research will be necessary before transbuccal Pitocin can be recommended for general use.

¶ Support for the practice of giving hydrocortisone to relieve shock due to blood loss came from a San Francisco research group. This report said cortisone can be lifesaving if it is given in large intravenous doses within thirty minutes after hemorrhagic shock sets in. It will effect spectacular elevations in blood pressure and maintain this elevation for long periods of time without blood replacement or other treatment. But no beneficial effect is achieved if cortisone is administered after shock becomes irreversible. The group defined irreversible shock as blood pressure below 50 mm. of mercury, enduring for forty-five minutes or longer.

¶ Two developments in hypothermia were reported. Surgeons from Johns Hopkins said they'd used hypothermia to reduce cerebral edema and consequent brain damage following resuscitation for cardiac arrest. And a research team from Northwestern University told of running ice water through an inflated balloon in a patient's stomach to induce hypothermia. This method, they said, reduces the temperature three times faster than does a refrigeration blanket alone. The patient can be warmed again in half the usual time by heating the water in the inflated balloon. The intragastric balloon is said to be especially useful in cases where the position on the O.R. table prevents adequate contact between the cooling blanket and the patient's body.

¶ Some anticancer drugs, it was reported, may accelerate tumor growth rather than depress it. This occurs when a toxic drug is ineffec-

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Because it contains AMBODRYL,[®] a potent antihistaminic, BENADRYL,[®] the time-tested antihistaminic-antispasmodic, plus three other well-recognized antitussive agents, AMBENYL EXPECTORANT acts swiftly to relieve cough due to colds or allergies and to ease discomfort. It soothes irritation, quiets the cough reflex, decongests nasal mucosa, decreases bronchospasm, and facilitates expectoration.

Each fluidounce of AMBENYL EXPECTORANT contains:

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(bromodiphenhydramine hydrochloride, Parke-Davis) 24 mg.

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Dihydrocodeinone bitartrate 1/6 gr.

Ammonium chloride 8 gr.

Potassium guaiacolsulfonate 8 gr.

Menthol q.s.

Alcohol 5%

Supplied in 16-ounce and 1-gallon bottles.

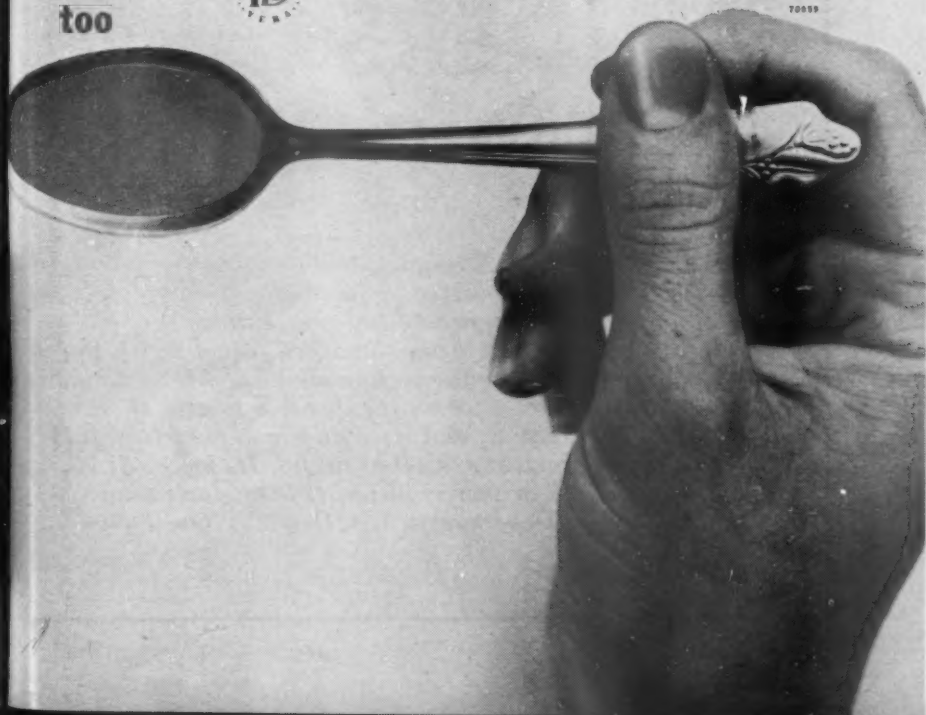
Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children, ½ to 1 teaspoonful.



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irritation
quiets
cough
and
tastes
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too



news

tive against the specific cancer it's being given for. Another report suggested that future choices of anticancer drugs will be governed by sensitivity tests. These would be similar to the method now used for determining the specific antibiotic for use against a specific organism.

¶ Surgeons at Ohio University have their patients eating string. The "string test" helps locate bleeding sites in the gastrointestinal tract. The patient swallows a length of umbilical tape, seven feet of which have been imprinted with a radiopaque marker. The tape is weighted to help it pass through

the pylorus. Two to three hours later, when the string is in place, the abdomen is X-rayed. The radiopaque markers make it possible to see the string in relation to the G.I. tract. When the patient has his next episode of bleeding, 10 ml. of fluorescein dye is given I.V. Five minutes later, the string is removed. The exact location of the bleeding point can then be determined by matching the string against the X-ray film. The string will show dye marking at the point where blood is pouring out of a vessel. The dye is made apparent by viewing the strip under an ultraviolet light in a dark room. END

BINDERS . . .

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RN

Your back issues of RN can now be bound neatly for ready reference in a red simulated-leather binder, specially designed to hold an entire year's issues of the magazine. Stamped in gold with the letters RN, the binder has been made available in response to numerous requests for an inexpensive means of preserving back issues; and if we do say so ourselves, it is particularly attractive as well as useful. Its price: \$1.75, payable by check or money order. (Please don't send cash.) Editorial Department, RN, Oradell, New Jersey

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GRADUATES: Mercy College of Anesthesiology offers an 18 mo AANA approved course to graduates of accredited schools of nursing. Write: Director, Anesthesia Dept., Most Carmel Mercy Hospital, Detroit 35, Mich.

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NURSES are appreciated people here at L.A. County General. With 6 mos. exp. they receive \$395 mo. Write me for more information. Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, Los Angeles 33, Calif.

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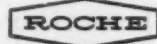
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